3 Years Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS ☐ yes ☐ no	PEDS Pathway:	Vision Chart Exam OD	OS	OU	Allergies:	Temp:	Pulse:	Resp:	B/P
Hearing Screening ☐ Unable to perform			Corrected ☐ yes ☐ no			Wt:	%	BMI:	%	Ht:	%
Rt. ☐ pass ☐ refer Lt. ☐ pass ☐ refer			☐ Unable to perform								
Speech: age appropriate ☐ yes ☐ no		Medications:									

PARENTAL CONCERNS/HISTORY:

DENTAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Brushing/flossing **(by parent)** daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: : ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ Uses imaginary characters ☐ Matches colors and shapes ☐ Counts to 5 ☐ Names self and others ☐ Knows gender ☐ Begins to play: games with simple rules/interactive games ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE:: [X] INDICATES GUIDANCE GIVEN: ☐ Sport helmet use ☐ Drowning prevention ☐ Emergency 911 ☐ Sun safety ☐ Nutrition/exercise ☐ Toilet training ☐ Discipline/redirect ☐ Reading/preschool ☐ Car Safety/booster seat/5 pt harness ☐ Provide opportunities for pretend & fantasy/problem solving & choices/drawing & scribbling ☐ Establish routine for: bed/meals/toileting etc. ☐ Allow child to play independently/be available if child seeks you out ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family adjustment/parent responds positively to child ☐ Self calming ☐ "Monster" fear ☐ Frustration/hitting/biting/impulse control ☐ Communication/language ☐ Pediatric Symptom Checklist ☐ Has words for feelings ☐ Separates easily from parent ☐ Objects to major change in routine ☐ Shows interest in other children ☐ Feels competent ☐ Kind to animals ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED:	[X] INDICATES ORDERED ☐ Hgb/Hct ☐ Urinalysis ☐ TB skin test (if at risk) ☐ Blood Lead Test **(perform at 36 – 72 months if not already done)** ☐ Other
IMMUNIZATIONS:	[X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent Refuses ☐ Other reason ☐ Had chicken pox ☐ HepA ☐ HepB ☐ MMR ☐ Varicella ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Influenza ☐ Other
REFERRALS:	[X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐PT ☐OT ☐ Audiology ☐ST ☐ Developmental ☐ Behavioral ☐ Dental ☐ Head Start ☐ Specialty ☐ Other

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**